

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>107</u>	Skilled (SNF)	<u>107</u>	<u>39,162</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>99</u>	Intermediate (ICF)	<u>99</u>	<u>36,234</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>206</u>	TOTALS	<u>206</u>	<u>75,396</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,000</u>	<u>972</u>	<u>2,556</u>	<u>9,528</u>	8
9	SNF/PED					9
10	ICF	<u>34,918</u>	<u>10,433</u>	<u>438</u>	<u>45,789</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>40,918</u>	<u>11,405</u>	<u>2,994</u>	<u>55,317</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.37%D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 7/1/93J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 7/1/93 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 2,054Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	Dietary	258,788	22,963	8,292	290,043		290,043	(54)	289,989			1
2	Food Purchase		227,270		227,270	(32,117)	195,154	(1,504)	193,649			2
3	Housekeeping	194,092	31,254		225,346		225,346		225,346			3
4	Laundry	70,915	21,272	1,104	93,291		93,291	(1,358)	91,933			4
5	Heat and Other Utilities			126,463	126,463		126,463	786	127,249			5
6	Maintenance	45,529	36,986	58,094	140,609		140,609	(12,197)	128,412			6
7	Other (specify):*							657	657			7
8	TOTAL General Services	569,324	339,745	193,953	1,103,022	(32,117)	1,070,906	(13,670)	1,057,235			8
9	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,777,702	149,072	74,064	2,000,838		2,000,838	(10,835)	1,990,003			10
10a	Therapy	15,073		928	16,001		16,001		16,001			10a
11	Activities	102,428	3,754	2,464	108,646		108,646		108,646			11
12	Social Services	49,168		2,593	51,761		51,761		51,761			12
13	Nurse Aide Training							121	121			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,944,371	152,826	86,049	2,183,246		2,183,246	(10,714)	2,172,532			16
17	C. General Administration											
17	Administrative	61,043			61,043		61,043	188,524	249,567			17
18	Directors Fees											18
19	Professional Services			313,601	313,601		313,601	(250,246)	63,355			19
20	Dues, Fees, Subscriptions & Promotions			75,420	75,420		75,420	(51,252)	24,168			20
21	Clerical & General Office Expenses	123,226	4,748	53,929	181,903		181,903	34,584	216,487			21
22	Employee Benefits & Payroll Taxes			379,633	379,633	32,117	411,750		411,750			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,545	1,545		1,545	486	2,031			24
25	Other Admin. Staff Transportation			9,662	9,662			29	9,691			25
26	Insurance-Prop.Liab.Malpractice			118,061	118,061		118,061	744	118,805			26
27	Other (specify):*							20,518	20,518			27
28	TOTAL General Administration	184,269	4,748	951,851	1,140,868	32,117	1,172,985	(56,613)	1,116,372			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,697,964	497,319	1,231,853	4,427,136		4,427,136	(80,997)	4,346,139			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

CARRINGTON CARE CENTER, LTD.
0038802
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #

<table border="1"><tr><td>22</td></tr></table>	22	EMPLOYEE BENEFITS	<u>32,117</u>	
22				
<table border="1"><tr><td>2</td></tr></table>	2	FOOD		<u>32,117</u>
2				

To reclass cost of employee meals from raw food to employee benefits

<table border="1"><tr><td>33</td></tr></table>	33	REAL ESTATE TAX	<u> </u>	
33				
<table border="1"><tr><td>19</td></tr></table>	19	PROFESSIONAL FEES		<u> </u>
19				

To reclass cost of appealing real estate taxes

Facility Name & ID Number **CARRINGTON CARE CENTER, LTD.**

#0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	Depreciation			36,404	36,404		36,404	14,877	51,281			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,657	33,657		33,657	(13,727)	19,930			32
33	Real Estate Taxes			141,272	141,272		141,272	1,849	143,121			33
34	Rent-Facility & Grounds			949,274	949,274		949,274		949,274			34
35	Rent-Equipment & Vehicles			16,292	16,292		16,292	7,691	23,983			35
36	Other (specify):*											36
37	TOTAL Ownership			1,176,899	1,176,899		1,176,899	10,690	1,187,589			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,713	96,933	164,646		164,646	(2,266)	162,380			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,094	113,094		113,094		113,094			42
43	Other (specify):*	48,223			48,223		48,223	(48,223)				43
44	TOTAL Special Cost Centers	48,223	67,713	210,027	325,963		325,963	(50,489)	275,474			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,746,187	565,032	2,618,779	5,929,998		5,929,998	(120,796)	5,809,202			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,590	30		9
10	Interest and Other Investment Income	(16,102)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(466)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(15,080)	21		18
19	Entertainment				19
20	Contributions	(45)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(48,353)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,397)	20		28
29	Other-Attach Schedule	(86,282)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (158,135)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	37,339		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 37,339		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (120,796)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6
2	Collection Fees	(4,583)	19
3	ICLTC Political Contributions	(296)	20
4	Marketing Salaries	(48,223)	43
5			5
6			6
7	Political Contributions	(1,500)	21
8	Trust Fees	(150)	21
9	Capitalized Repairs & Maintenance	(19,932)	6
10	Prior Period Seminar Expense	(150)	24
11	PPA - Medical Supplies	(295)	10
12	PPA - Maintenance	(546)	6
13	PPA - Food	(1,038)	2
14	PPA - Laundry Supplies	(254)	4
15	PPA - Clerical & General	(102)	21
16	PPA - Dietary Supplies	(54)	1
17	PPA - Laundry	(1,104)	4
18	Discounts Earned	(1,335)	10
19	Veteran's Prescription Drugs	(6,722)	10
20			20
21			21
22			22
23			23
24			24
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83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(86,282)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802 Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(54)											(54)	1
2	Food Purchase	(1,504)											(1,504)	2
3	Housekeeping													3
4	Laundry	(1,358)											(1,358)	4
5	Heat and Other Utilities			786									786	5
6	Maintenance	(20,478)		4,015	4,266								(12,197)	6
7	Other (specify):*			113		544							657	7
8	TOTAL General Services	(23,394)		4,914	4,266	544							(13,670)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(8,350)						(2,485)					(10,835)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training			121									121	13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(8,350)		121				(2,485)					(10,714)	16
	C. General Administration													
17	Administrative				188,524								188,524	17
18	Directors Fees													18
19	Professional Services	(4,583)		(245,663)									(250,246)	19
20	Fees, Subscriptions & Promotions	(52,046)		794									(51,252)	20
21	Clerical & General Office Expenses	(16,877)		47,468	3,993								34,584	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(150)		636									486	24
25	Other Admin. Staff Transportation			29									29	25
26	Insurance-Prop.Liab.Malpractice			744									744	26
27	Other (specify):*			6,292		14,226							20,518	27
28	TOTAL General Administration	(73,656)		(189,700)	192,517	14,226							(56,613)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(105,400)		(184,665)	196,783	14,770		(2,485)					(80,997)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	11,590		3,287									14,877	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,102)		2,375									(13,727)	32
33	Real Estate Taxes			1,849									1,849	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles			7,691									7,691	35
36	Other (specify):*													36
37	TOTAL Ownership	(4,512)		15,202									10,690	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2,266)					(2,266)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(48,223)											(48,223)	43
44	TOTAL Special Cost Centers	(48,223)						(2,266)					(50,489)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(158,135)		(169,463)	196,783	14,770		(4,751)					(120,796)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		Carrington Care Center Bldg. Corp.		Building
				See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34	Rent	\$ 949,274	Carrington Care Center Bldg. Corp.		\$ 949,274	\$	1
2	V	34	Rent Expense		Carrington Care Ctr. Building Corp.				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 949,274			\$ 949,274	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 786	\$ 786	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.	100.00%	4,015	4,015	16
17	V	7 EMP.BEN. - GEN. SERVICES		DYNAMIC HEALTH CARE CONS.	100.00%	113	113	17
18	V	13 NURSES AIDE TRAINING		DYNAMIC HEALTH CARE CONS.	100.00%	121	121	18
19	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.	100.00%	1,897	1,897	19
20	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.	100.00%	794	794	20
21	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.	100.00%	47,468	47,468	21
22	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.	100.00%	636	636	22
23	V	25 ADMIN. STAFF TRANS.		DYNAMIC HEALTH CARE CONS.	100.00%	29	29	23
24	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.	100.00%	744	744	24
25	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.	100.00%	6,292	6,292	25
26	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.	100.00%	3,287	3,287	26
27	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.	100.00%	2,375	2,375	27
28	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.	100.00%	1,849	1,849	28
29	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.	100.00%	7,691	7,691	29
30	V							30
31	V							31
32	V	19 HOME OFFICE BOOKKEEPING	247,560	DYNAMIC HEALTH CARE CONS.			(247,560)	32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 247,560			\$ 78,097	\$ * (169,463)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 4,266	\$ 4,266
16	V	10 NURSING CMP - SUE G.		DYNAMIC HEALTH CARE CONS.	100.00%		
17	V	17 ADMIN. CMP. - M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	34,432	34,432
18	V	17 ADMIN. CMP. - M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	44,042	44,042
19	V	17 ADMIN. CMP. - F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%		
20	V	17 ADMIN. CMP. - A. STERN		DYNAMIC HEALTH CARE CONS.	100.00%	27,764	27,764
21	V	17 ADMIN. CMP. - S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	35,816	35,816
22	V	17 ADMIN. CMP. - S. KOPLIN		DYNAMIC HEALTH CARE CONS.	100.00%	8,113	8,113
23	V	17 ADMIN. CMP. - D. MAGAFAS		DYNAMIC HEALTH CARE CONS.	100.00%		
24	V	17 ADMIN. CMP. - E. CASSON		DYNAMIC HEALTH CARE CONS.	100.00%	10,989	10,989
25	V	17 ADMIN. CMP. - S. BOGEN		DYNAMIC HEALTH CARE CONS.	100.00%		
26	V	17 ADMIN. CMP. - S. LEVY		DYNAMIC HEALTH CARE CONS.	100.00%	10,025	10,025
27	V	17 ADMIN. CMP. - A. STEINER		DYNAMIC HEALTH CARE CONS.	100.00%	3,275	3,275
28	V	17 ADMIN. CMP. - NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	14,068	14,068
29	V	21 CLERICAL CMP. - S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	3,993	3,993
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 196,783	\$ * 196,783

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 544	\$ 544	15
16	V	15 EMP. BEN.- SUE G.		DYNAMIC HEALTH CARE CONS.	100.00%			16
17	V	27 EMP. BEN.- M. MAUER		DYNAMIC HEALTH CARE CONS.	100.00%	962	962	17
18	V	27 EMP. BEN.- M. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	1,117	1,117	18
19	V	27 EMP. BEN.- F. AARON		DYNAMIC HEALTH CARE CONS.	100.00%			19
20	V	27 EMP. BEN.- S. GOLDSTEIN		DYNAMIC HEALTH CARE CONS.	100.00%	3,703	3,703	20
21	V	27 EMP. BEN.- S. KOPLIN		DYNAMIC HEALTH CARE CONS.	100.00%	1,728	1,728	21
22	V	27 EMP. BEN.- D. MAGAFAS		DYNAMIC HEALTH CARE CONS.	100.00%			22
23	V	27 EMP. BEN.- E. CASSON		DYNAMIC HEALTH CARE CONS.	100.00%	2,360	2,360	23
24	V	27 EMP. BEN.- S. BOGEN		DYNAMIC HEALTH CARE CONS.	100.00%			24
25	V	27 EMP. BEN.- S. LEVY		DYNAMIC HEALTH CARE CONS.	100.00%	1,374	1,374	25
26	V	27 EMP. BEN.- A. STEINER		DYNAMIC HEALTH CARE CONS.	100.00%	544	544	26
27	V	27 EMP. BEN.- NON-OWNER		DYNAMIC HEALTH CARE CONS.	100.00%	1,892	1,892	27
28	V	27 EMP. BEN.- S. AARON		DYNAMIC HEALTH CARE CONS.	100.00%	546	546	28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 14,770	\$ * 14,770	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V	10 NURSING & MEDICAL SUPPLY	\$ 13,316	PHARMCOR, L.L.C.	100.00%	\$ 13,316	\$		15
16	V	22 EMPLOYEE BENEFITS	0	PHARMCOR, L.L.C.	100.00%				16
17	V	39 ANICILLARY EXPENSE	48,593	PHARMCOR, L.L.C.	100.00%	48,593			17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 61,909			\$ 61,909	\$ *		39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V	20 DUES, FEES & SUBSCRIPTIONS	\$ 0	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	\$ 0	
16	V	10 MEDICAL SUPPLIES	9,444	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	6,959	(2,485)
17	V	39 ANCILLARY EXPENSE	8,612	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	6,346	(2,266)
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 18,056			\$ 13,305	\$ * (4,751)

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A THERAPY	\$ 928	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	\$ 928	\$	15
16	V	22 EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	39 ANCILLARY SERVICES	22,260	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	22,260		17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 23,188			\$ 23,188	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **CARRINGTON CARE CENTER, LTD.**# **0038802**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD. # 0038802 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Maury Aaron	Owner	Administrative	21.60%	See Attached	3.6	7.2%	Alloc-Dynamic	\$ 44,042	17-7	1
2	Marshall Mauer	Owner	Administrative	12.14%	See Attached	3.2	6.4%	Alloc-Dynamic	34,432	17-7	2
3	Abe Stern	Owner	Administrative	7.28%	See Attached	0.63	1.26%	Alloc-Dynamic	27,764	17-7	3
4	Sharon Aaron	Relative	Clerical		See Attached	3.16	7.90%	Alloc-Dynamic	3,993	21-7	4
5	Sue Koplin	Owner	Administrative	2.85%	See Attached	5.39	11.97%	Alloc-Dynamic	8,113	17-7	5
6	Dennis Nehmer	Owner	Maintenance	2.37%	See Attached	3.16	7.90%	Alloc-Dynamic	4,266	6-7	6
7	Steven Goldstein	Owner	Administrative	12.14%	See Attached	10	20.00%	Alloc-Dynamic	35,816	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 158,426		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	15	\$ 10,055	\$ 16,071	55,317	\$ 786	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	15	51,362		55,317	4,015	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	15	1,448		55,317	113	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	15	1,550		55,317	121	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	15	24,272		55,317	1,897	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	15	10,163		55,317	794	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	15	607,305	465,093	55,317	47,468	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	15	8,134		55,317	636	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	15	372		55,317	29	9
10	26	INSURANCE	PATIENT DAYS	15	9,517		55,317	744	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	15	80,498		55,317	6,292	11
12	30	DEPRECIATION	PATIENT DAYS	15	42,057		55,317	3,287	12
13	32	INTEREST	PATIENT DAYS	15	30,386		55,317	2,375	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	15	23,654		55,317	1,849	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	15	98,401		55,317	7,691	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 999,174	\$ 481,163		\$ 78,097	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	14	54,000	54,000	3	4,266	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	32,209	32,209			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	14	435,842	435,842	3	34,432	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	14	558,156	558,156	4	44,042	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	50	7	160,040	160,040			5
6	17	ADMIN. CMP. - A. STERN	WGHTD. AVG. HOURS	8	14	351,664		1	27,764	6
7	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	179,079	179,079	10	35,816	7
8	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	10	67,732	67,732	5	8,113	8
9	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	10	82,127	82,127			9
10	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	45	2	47,882	47,882	10	10,989	10
11	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	119,320	119,320			11
12	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	14	126,974	126,974	4	10,025	12
13	17	ADMIN. CMP. - A. STEINER	WGHTD. AVG. HOURS	45	14	41,511	41,511	4	3,275	13
14	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	14	178,292	178,292	4	14,068	14
15	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	14	50,548	50,548	3	3,993	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,485,376	\$ 2,133,711		\$ 196,783	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC HEALTH CARE CONS.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	6,887		3	544	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40	2,883				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	12,175		3	962	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45	14,155		4	1,117	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	50	19,744				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50	18,514		10	3,703	6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45	14,423		5	1,728	7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	13,516				8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	45	10,284		10	2,360	9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45	7,029				10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55	17,400		4	1,374	11
12	27	EMP. BEN.- A. STEINER	WGHTD. AVG. HOURS	45	6,891		4	544	12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	23,984		4	1,892	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	6,917		3	546	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 174,802	\$		\$ 14,770	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PHARMCOR, L.L.C.Street Address 3116 S. OAK PARKCity / State / Zip Code BERWYN, IL 60402Phone Number (708)795-7701Fax Number ()

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPL	DIRECT ALLOCATION					13,316	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						2
3	39	ANICILLARY EXPENSE	DIRECT ALLOCATION					48,593	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 61,909	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	DUES, FEES & SUBSCRIPTION	DIRECT ALLOCATION						1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION					6,959	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION					6,346	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 13,305	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization DYNAMIC REHAB CONSULTANTS, L.L.C.
 Street Address 3359 W. MAIN STREET
 City / State / Zip Code SKOKIE, IL. 60076
 Phone Number (847) 679-8219
 Fax Number (847) 679-7377

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION					928	1
2	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						2
3	39	ANCILLARY SERVICES	DIRECT ALLOCATION					22,260	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 23,188	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number	CARRINGTON CARE CENTER, LTD.
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0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Bank Leumi		X	Line of Credit	6/30/1998			1,000,000	425,000		8.75%	33,657	6
7													7
8													8
9	TOTAL Facility Related				\$35,976.00		\$	1,000,000	\$ 425,000			\$ 33,657	9
	B. Non-Facility Related*												
10	Supplemental Schedule												10
11	Interest Income											(16,102)	11
12	Allocation from Dynamic	X										2,375	12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$ (13,727)	14
15	TOTALS (line 9+line14)						\$	1,000,000	\$ 425,000			\$ 19,930	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.**

(See instructions.)

Facility Name & ID Number

CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
1							\$		\$			\$	1						
2													2						
3													3						
4													4						
5													5						
6													6						
7													7						
8													8						
9													9						
10													10						
11													11						
12													12						
13													13						
14													14						
15													15						
16													16						
17													17						
18													18						
19													19						
20													20						
21							\$		\$			\$	21						

Facility Name & ID Number **CARRINGTON CARE CENTER, LTD.**# **0038802**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	125,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	132,121	2
3. Under or (over) accrual (line 2 minus line 1).	\$	7,121	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	136,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	143,121	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	117,869	8
	1996	119,488	9
	1997	117,983	10
	1998	121,074	11
	1999	130,272	12

R/E Tax Accrual - \$130,272 * 1.05 = \$136,785 (\$136,000 rounded)

Related Party Allocation = 1849

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1993		26,220	673	20	1,312	639	9,357	9
10	Various		1994		118,541	2,718	20	5,928	3,210	39,245	10
11	Various		1995		26,846	512	20	1,343	831	7,559	11
12	COOLING TOWER REPAIR		1996		501	13	20	25	12	119	12
13	COOLING TOWER REPAIR		1996		834	21	20	42	21	203	13
14	COOLING TOWER REPAIR		1996		1,060	27	20	53	26	252	14
15	COOLING TOWER REPAIR		1996		530	14	20	27	13	128	15
16	COOLING TOWER REPAIR		1996		425	11	20	21	10	100	16
17	COOLING TOWER REPAIR		1996		2,239	57	20	112	55	523	17
18	COOLING TOWER REPAIR		1996		1,646	42	20	82	40	383	18
19	COOLING TOWER REPAIR		1996		458	12	20	23	11	105	19
20	COOLING TOWER REPAIR		1996		336	9	20	17	8	78	20
21	CONDENSING UNIT		1996		5,181	133	20	259	126	1,101	21
22	ROOF REPAIR		1996		4,532	116	20	227	111	1,097	22
23	HOT WATER BOILER REP		1996		2,429	62	20	121	59	484	23
24											24
25	PAGE 12-I REP TOTALS				34,672	889		991	102	7,265	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				27,292	97		1,082	985	1,082	33
34	PAGE 12B TOTALS				62,274	1,376		2,443	1,067	4,202	34
35	PAGE 12A TOTALS				187,490	5,359		9,376	4,017	33,366	35
36	TOTAL (lines 4 thru 35)				\$ 503,506	\$ 12,141		\$ 23,484	\$ 11,343	\$ 106,649	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		ALARM REPAIRS		1996	847	22	20	42	20	200	9
10		ALARM REPAIRS		1996	1,078	28	20	54	26	257	10
11		ALARM REPAIRS		1996	781	20	20	39	19	185	11
12		ELEVATOR REPAIR		1996	6,100	156	20	305	149	1,373	12
13		COOLING TOWER REPAIR		1996	669	17	20	33	16	151	13
14		COOLING TOWER REPAIR		1996	794	20	20	40	20	183	14
15		ROOF REPAIR		1996	5,000	128	20	250	122	1,104	15
16		WATER SOFTNER SYSTEM		1997	9,500	244	20	475	231	1,781	16
17		LIGHT FIXTURES		1997	604	15	20	30	15	115	17
18		AIR CONDITIONING		1997	60,200	1,544	20	3,010	1,466	11,789	18
19		WATER SOFTNER BURNER		1997	733	19	20	37	18	142	19
20		WATERMIXING BURNERS		1997	760	19	20	38	19	146	20
21		HEATING & A/C REPAIR		1997	5,763	148	20	288	140	1,104	21
22		TILE IN SHOWERS		1997	5,215	134	20	261	127	870	22
23		ROOFWORK		1997	39,950	1,024	20	1,998	974	6,660	23
24		NURSE CALL SYSTEM		1997	4,792	674	20	240	(434)	999	24
25		HEATING & A/C REPAIR		1997	1,535	39	20	77	38	308	25
26		TRANSFER SWITCH		1998	2,179	56	20	109	53	291	26
27		FLOORS REHAB		1998	1,471	38	20	74	36	185	27
28		ELEVATOR PUMP & HOSE		1998	1,826	47	20	91	44	228	28
29		SHELVING		1998	1,561	40	20	78	38	234	29
30		AIR HANDLER		1998	1,117	29	20	56	27	168	30
31		COOLING TOWER		1998	7,327	188	20	366	178	1,068	31
32		NEW CONDENSOR		1998	3,754	96	20	188	92	533	32
33		DOOR		1998	984	25	20	49	24	135	33
34		ELEVATOR		1998	12,500	321	20	625	304	1,719	34
35		WATER TOWER		1998	10,450	268	20	523	255	1,438	35
36		TOTAL (lines 4 thru 35)			\$ 187,490	\$ 5,359		\$ 9,376	\$ 4,017	\$ 33,366	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		KITCHEN PIPE LINE		1998	7,806	200	20	390	190	943	9
10		PAINT & DECORATIONS		1998	3,143		20	157	157	314	10
11		TELEPHONE SYSTEM		1998	1,363	238	20	68	(170)	227	11
12		FIRE DAMPER		1998	2,040	52	20	102	50	213	12
13		MAGNETIC DOOR		1998	800	21	20	40	19	83	13
14		TELEPHONE SYSTEM		1998	1,115	195	20	56	(139)	196	14
15		CONDENSOR		1999	2,160	55	20	108	53	135	15
16		FIRE DAMPERS		1999	1,499	38	20	75	37	150	16
17		FIRE ALARM		1999	586	15	20	29	14	51	17
18		CIRCUIT SETTER		1999	1,096	28	20	55	27	92	18
19		COOLER REPAIR		1999	3,925	101	20	196	95	245	19
20		SPRINKLER REPAIRS		1999	1,397		20	70	70	140	20
21		AIR CLEANER		1999	1,848		20	92	92	161	21
22		FIRE ALARM REPAIR		1999	902	23	20	45	22	56	22
23		FRONT DOOR		1999	1,395	36	20	70	34	140	23
24		CAMERA & MONITOR		1999	1,545		20	77	77	141	24
25		FIRE ALARM REPAIR		1999	600	15	20	30	15	40	25
26		MODULATING VALVE		1999	2,760	71	20	138	67	230	26
27		REMODELING		2000	9,180	88	20	191	103	191	27
28		CARPET/TILE		2000	4,394	52	20	110	58	110	28
29		CUSTOM CABINETS		2000	6,046	71	20	151	80	151	29
30		INSTALL HANDRAIL		2000	263	3	20	7	4	7	30
31		INSTALL HANDRAIL		2000	1,163	14	20	29	15	29	31
32		HANDRAILS/BUMPERS		2000	2,879	40	20	84	44	84	32
33		TILE		2000	660	9	20	19	10	19	33
34		WALLPAPER		2000	610		20	31	31	31	34
35		TILING		2000	1,099	11	20	23	12	23	35
36		TOTAL (lines 4 thru 35)			\$ 62,274	\$ 1,376		\$ 2,443	\$ 1,067	\$ 4,202	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOW TREATMENT			2000	2,366	8	20	20	12	20	9
10	AIR CONDITIONING			2000	868		20	43	43	43	10
11	WALL SWITCHES			2000	1,631	16	20	34	18	34	11
12	SMOKE DETECTOR			2000	659		20	33	33	33	12
13	ELECTRICAL WORK			2000	2,850	40	20	83	43	83	13
14	DIALYSIS ROOM			2000	411	3	20	7	4	7	14
15	FAUCETS/PLUMBING			2000	611		20	31	31	31	15
16	WALLPAPER			2000	2,325		20	116	116	116	16
17	GAS VALVE			2000	756		20	38	38	38	17
18	REPLACE VALVE			2000	640	3	20	8	5	8	18
19	WALLPAPER			2000	3,758		20	188	188	188	19
20	FIRE ALARM			2000	706		20	35	35	35	20
21	TILE			2000	1,921	27	20	56	29	56	21
22	PAINTING			2000	7,790		20	390	390	390	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 27,292	\$ 97		\$ 1,082	\$ 985	\$ 1,082	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
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14												
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26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
14												
15												
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25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
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29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4			1993	Dynamic	\$ 34,672	\$ 889	35	\$ 991	\$ 102	\$ 7,265
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
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28										
29										
30										
31										
32										
33										
34										
35										
36	TOTAL (lines 4 thru 35)				\$ 34,672	\$ 889		\$ 991	\$ 102	\$ 7,265

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.# 0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												
11												
12												
13												
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24												
25												
26												
27												
28												
29												
30												
31												
32												
33												
34												
35												
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **CARRINGTON CARE CENTER, LTD.**# **0038802**

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 234,551	\$ 22,969	\$ 26,380	\$ 3,411		\$ 118,543	37
38	Current Year Purchases	21,752	3,612	1,210	(2,402)		1,210	38
39	Fully Depreciated Assets		730		(730)			39
40								40
41	TOTALS	\$ 256,303	\$ 27,311	\$ 27,590	\$ 279		\$ 119,753	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Allocation from Dynamic			\$ 1,243	\$ 239	\$ 207	\$ (32)	6	\$ 207	42
43										43
44										44
45										45
46	TOTALS			\$ 1,243	\$ 239	\$ 207	\$ (32)		\$ 207	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 761,052	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 39,691	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 51,281	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 11,590	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 226,609	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

CARRINGTON CARE CENTER, LTD.
0038802
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Building	215,545	21,073	24,518	3,445	109,525
Dynamic Health Care Consultants	19,006	1,896	1,862	(34)	9,018
TOTALS	234,551	22,969	26,380	3,411	118,543

LINE 29: CURRENT YEAR

Building	20,435	3,349	1,144	(2,205)	1,144
Dynamic Health Care Consultants	1,317	263	66	(197)	66
TOTALS	21,752	3,612	1,210	(2,402)	1,210

LINE 30: FULLY DEPRECIATED

Building		730		(730)	
Dynamic Health Care Consultants					
TOTALS		730		(730)	

TOTALS (Should Tie to Totals on Page 13)

Building	235,980	25,152	25,662	510	110,669
Dynamic Health Care Consultants	20,323	2,159	1,928	(231)	9,084
TOTALS	256,303	27,311	27,590	279	119,753

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning:

01/01/00

Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Carrington Building, LLC pays Fox Valley Health Care (Unrelated Party)

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions		206		949,274			4
5								5
6								6
7	TOTAL		206		\$ 949,274			7

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. 2001 \$ 968,131

13.	<u>2002</u>	\$ <u>986,869</u>
-----	-------------	-------------------

14.	<u> </u>	<u> </u>	<u> </u>	<u> </u>
		/2003	\$	1005666

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 13,901 Description: \$3250 - Respiratory Equipment; \$2960 - Copier; \$7691 Allocation from Dynamic
(Attach a schedule detailing the breakdown of movable equipment)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Vehicle	\$ 840.20	\$ 10,082	17
18					18
19					19
20					20
21	TOTAL		\$ 840.20	\$ 10,082	21

*** If there is an option to buy the building, please provide complete details on attached schedule.**

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

Facility Name & ID Number

CARRINGTON CARE CENTER, LTD.

#

0038802

Report Period Beginning:

01/01/00

Ending:

12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☒ YES☐ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				Allocated
6	Transportation				from
7	Contractual Payments				Dynamic
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$ 121
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 32,751	\$		\$ 32,751	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			3,602			3,602	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			56,690			56,690	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				51,727		51,727	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**					3,890	15,986		19,876	13
14	TOTAL			\$		\$ 96,933	\$ 67,713		\$ 164,646	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	10,202
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5 Medical Supplies - Rental	5,784
6	
7	
8	
9	
10	
	<u>15,986</u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2 Laboratory	2,336
3 Radiology	1,554
4	
5	
6	
7	
8	
9	
10	
	<u>3,890</u>

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 52,095	\$ 52,108	1
2 Cash-Patient Deposits	42,898	42,898	2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	501,507	501,507	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance	50,075	50,075	6
7 Other Prepaid Expenses	3,305	3,305	7
8 Accounts Receivable (owners or related parties)	231,113	231,513	8
9 Other(specify): See supplemental schedule	125,519	146,119	9
TOTAL Current Assets			
10 (sum of lines 1 thru 9)	\$ 1,006,512	\$ 1,027,525	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land			13
14 Buildings, at Historical Cost			14
15 Leasehold Improvements, at Historical Cos	416,211	416,211	15
16 Equipment, at Historical Cost	264,959	264,959	16
17 Accumulated Depreciation (book methods)	(266,659)	(266,659)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): See supplemental schedule			23
TOTAL Long-Term Assets			
24 (sum of lines 11 thru 23)	\$ 414,511	\$ 414,511	24
TOTAL ASSETS			
25 (sum of lines 10 and 24)	\$ 1,421,023	\$ 1,442,036	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 232,231	\$ 232,231	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	42,898	42,898	28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	183,042	183,042	30
31 Accrued Taxes Payable (excluding real estate taxes)	5,116	5,116	31
32 Accrued Real Estate Taxes(Sch.IX-B)	136,000	136,000	32
33 Accrued Interest Payable	3,449	3,449	33
34 Deferred Compensation			34
35 Federal and State Income Taxes	8,305	8,305	35
Other Current Liabilities(specify):			
36 See supplemental schedule	4,393	4,393	36
37			37
TOTAL Current Liabilities			
38 (sum of lines 26 thru 37)	\$ 615,434	\$ 615,434	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable	425,000	425,000	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See supplemental schedule		21,013	43
44			44
TOTAL Long-Term Liabilities			
45 (sum of lines 39 thru 44)	\$ 425,000	\$ 446,013	45
TOTAL LIABILITIES			
46 (sum of lines 38 and 45)	\$ 1,040,434	\$ 1,061,447	46
TOTAL EQUITY (page 18, line 24)	\$ 380,589	\$ #REF!	47
TOTAL LIABILITIES AND EQUITY			
48 (sum of lines 46 and 47)	\$ 1,421,023	\$ #REF!	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 626,472	1
2	Restatements (describe):		2
3	Schedule attached	(520)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 625,952	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,163)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(41,200)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (245,363)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 380,589	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number	CARRINGTON CARE CENTER, LTD#	0038802	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	625,952
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Adjustments:

-

-

-

State Replacement Tax	520
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Total adjustments	520
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Balance - Beginning of Year	626,472
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Equity(Deficit) from Page 17 Col 1	380,589
------------------------------------	---------

Related Party

Equity(Deficit)	0
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Income	0
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Combined Equity - End of Year	380,589
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Facility Name & ID Number CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,608,236	1
2	Discounts and Allowances for all Levels	(501,160)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,107,076	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	442,080	6
7	Oxygen	11,685	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 453,765	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,200	13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,591	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,723	19
20	Radiology and X-Ray	2,331	20
21	Other Medical Services	58,714	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 147,559	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,102	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,102	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,333	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,333	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,725,835	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,103,022	31
32	Health Care	2,183,246	32
33	General Administration	1,140,868	33
	B. Capital Expense		
34	Ownership	1,176,899	34
	C. Ancillary Expense		
35	Special Cost Centers	212,869	35
36	Provider Participation Fee	113,094	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,929,998	40
41	Income before Income Taxes (line 30 minus line 40)**	(204,163)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (204,163)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? [Not Available](#) If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 Vending Commissions	
2 Discounts Earned (Adjusted out on page 5)	1,333
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	1,333

Facility Name & ID Number **CARRINGTON CARE CENTER, LTD.**# **0038802**

Report Period Beginning:

01/01/00

Ending:

12/31/00**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,510	1,976	\$ 48,525	\$ 24.56	1
2	Assistant Director of Nursing	1,243	1,267	28,272	22.31	2
3	Registered Nurses	35,091	38,484	810,395	21.06	3
4	Licensed Practical Nurses	8,344	8,666	168,648	19.46	4
5	Nurse Aides & Orderlies	64,317	65,193	710,300	10.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	483	499	15,073	30.21	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,253	1,471	19,004	12.92	9
10	Activity Assistants	10,216	11,219	83,424	7.44	10
11	Social Service Workers	4,132	4,425	49,168	11.11	11
12	Dietician	4,097	4,196	70,945	16.91	12
13	Food Service Supervisor					13
14	Head Cook	6,385	7,096	68,929	9.71	14
15	Cook Helpers/Assistants	16,207	17,473	118,914	6.81	15
16	Dishwashers					16
17	Maintenance Workers	3,794	4,084	45,529	11.15	17
18	Housekeepers	25,223	26,970	194,092	7.20	18
19	Laundry	9,643	10,271	70,915	6.90	19
20	Administrator	1,453	1,551	52,635	33.94	20
21	Assistant Administrator	492	612	8,408	13.74	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,727	12,921	123,226	9.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,172	1,240	11,562	9.32	31
32	Other Health Care(specify)					32
33	Other(specify)	4,052	4,339	48,223	11.11	33
34	TOTAL (lines 1 - 33)	210,834	223,953	\$ 2,746,187 *	\$ 12.26	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	246	\$ 8,292	1-3	35
36	Medical Director	Monthly	6,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	2,719	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	4	140	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	23	788	10a-3	43
44	Activity Consultant	56	2,464	11-3	44
45	Social Service Consultant	52	2,593	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	477	\$ 22,996		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,616	\$ 67,816	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides	79	3,529	10-3	52
53	TOTAL (lines 50 - 52)	1,695	\$ 71,345		53

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number CARRINGTON CARE CENTER, LTD.

0038802

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$6579
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,225 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? X YES _____ NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 113,094
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 32,117 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw